Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Rural Health Care Support Mechanism	)	WC Docket No. 02-60
	)	DA 07-1237
American Telemedicine Association Petition for Reconsideration of the Rural Health Care support Mechanism Second Report and Order	)	

NATIONAL TELECOMMUNICATIONS COOPERATIVE ASSOCIATION
REPLY COMMENTS

The National Telecommunications Cooperative Association (NTCA)[1] files these reply comments in response to initial comments filed April 12, 2007, regarding the American Telemedicine Association's (ATA) Petition to the Federal Communications Commission (Commission or FCC) for Reconsideration of the Rural Health Care Support Mechanism Second Report and Order regarding the definition of "rural" (Petition).[2] NTCA urges the Commission to grant the ATA Petition and to acknowledge that this definition of "rural" applies only to the rural health care portion of the USF and not necessarily to other funding programs within the USF.

I. Background.

The Commission issued a Public Notice on March 13, 2007, seeking comment on the ATA Petition, which asks the Commission to grandfather indefinitely the eligibility for rural

[1] NTCA is the premier industry association representing rural telecommunications providers. Established in 1954 by eight rural telephone companies, today NTCA represents 575 rural rate-of-return regulated incumbent local exchange carriers (ILECs). All of its members are full service local exchange carriers, and many members provide wireless, cable, Internet, satellite and long distance services to their communities. Each member is a "rural telephone company" as defined in the Communications Act of 1934, as amended (Act). NTCA members are dedicated to providing competitive modern telecommunications services and ensuring the economic future of their rural communities.

[2] American Telemedicine Association Petition for Reconsideration of the Rural Health Care Support Mechanism Second Report and Order, WC Docket No. 02-60 (filed Mar. 7, 2005) (Petition).

health care providers that have qualified for rural health care funding under prior definitions of "rural" since 1998.[3] The Commission created its first standard of "rural" for the USF rural health care support mechanism in its 1997 *Universal Service Order* in which it concluded that:

> [T]elecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account. The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider. Finally, the Commission adopted an annual cap of $400 million for universal service support for rural health care providers. The Commission based its conclusions on analysis of the condition of the rural health care community and technology at that time.[4]

In its 2004 *Second Report and Order*, the Commission changed one aspect of the definition of "rural" from under 50,000 population to under 25,000 population for purposes of the USF rural health care support mechanism but allowed previously-funded health care providers to continue qualifying for funding for an additional three years.[5] Specifically, the new test is as follows:

> Whether an area is "rural" is determined by applying the following test. If an area is outside of any Core Based Statistical Area (CBSA), it is rural. Areas within CBSAs can be either rural or nonrural, depending on the characteristics of the CBSA. Small CBSAs – those that do not contain an urban area with populations of 25,000 or more – are rural. Within large CBSAs – those that contain urban areas with populations of 25,000 or more – census tracts can be either rural or non-rural depending on the characteristics of the particular census tract. If a census tract in a large CBSA does not contain any part of a place or urban area with a population greater than 25,000, then that tract is rural.

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[3] *Comment Sought on American Telemedicine Association's Petition for Reconsideration of the Rural Health Care Support Mechanism Second Report and Order*, WC Docket No. 02-60, Public Notice (rel. Mar. 13, 2007).

[4] *In the Matter of Rural Health Care Support Mechanism*, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60, 19 FCC Rcd 24613 (rel. Dec. 17, 2004), (Second Report and Order), ¶ 4, *citing 1997 Universal Service Order*, 12 FCC Rcd 8776, ¶ 608.

[5] ATA contends that the 25,000 population threshold was set because "the Commission stated that they believed that urban areas above 25,000 possess a critical mass of populations and facilities." Petition at 7-8; Second Report and Order, ¶ 15.

> Alternatively, if a census tract in a large CBSA contains all or part of a place or urban area with a population that exceeds 25,000, then it is not rural.[6]

The Commission made this and other changes to the rural health care support mechanism "to make it more viable and to reflect technological changes."[7] These changes went into effect July 1, 2005, and all rural health care providers that had received funding commitments since 1998 from USAC were given a three-year transition time (presumably until June 30, 2008) to meet the new definition of "rural."[8]

The three-year period will expire next year, together with certain health care providers' rural status and eligibility for USF rural health care support, according to ATA.[9]

II. All Commenters Agree That The Commission Should Grant The ATA Petition.

ATA asserts that its Petition did not seek to override the Commission's new definition of "rural" but sought only to grandfather sites eligible as of the date of the Second Report and Order.[10] ATA notes that under the new definition, "there are other areas that are a significant distance from the nearest tertiary care hospital or health care facility, with populations significantly lower than 25,000, that are now not considered rural."[11] The Petition cites several specific examples of rural health care providers in Nebraska, Montana and Virginia, noting that

[6] Second Report and Order, ¶ 12.

[7] Second Report and Order, ¶ 5.

[8] Second Report and Order, ¶¶ 13, 23.

[9] Petition at 5.

[10] Petition at 3.

[11] Petition at 5.

these hospitals and telehealth networks will lose their funding eligibility through the USF rural health care funding mechanism if they are not grandfathered under the 2005 definition.

All commenters in this proceeding -- rural health care providers from Virginia, Nebraska, South Dakota, Hawaii and California, and the Nebraska Public Service Commission -- support ATA's Petition and cite specific rural medical care facilities and/or communities that will lose funding eligibility if not grandfathered under the definition of what it means to be "rural" for this specific purpose.[12] These commenters agree that the Commission should grant the ATA Petition and extend indefinitely the grandfathering of those health care providers who previously satisfied the definition of "rural" for purposes of the USF rural health care program. NTCA agrees that this approach is sound as it will benefit rural health care providers and their patients, some of whom reside in NTCA member territories.[13] Clearly there is a public benefit to rural health care providers and their patients in allowing the existing qualified recipients to remain on the rural health care qualification list. NTCA joins the chorus of supporters for the ATA Petition.

III. The Commission Should Clarify That The USF Rural Health Care Definition of "Rural" Does Not Necessarily Apply To Other USF Programs.

While all commenters support the Petition, one key aspect of the definition is the context in which it is to be applied – the rural health care program. The main reason the Commission changed the definition of "rural" in 2004 was to "improve the effectiveness of the rural health

[12] California Primary Care Association Comment, p. 1; California / Northern Sierra Rural Services Comment, p. 1; Hawaii VA Hospital Comment, p. 1; Nebraska Public Service Commission Comment, p. 3; Nebraska Telehealth Network Comment, p. 2; Avera St. Luke's Telehealth Services (South Dakota) Comment, p. 1; University of Virginia Medical Center Office of Telemedicine Comment, pp. 1, 7, 8; South River Consultants of Virginia Comment, pp. 5, 6.

[13] Several commenters raise other issues in their filings. NTCA silence on any positions or proposals raised by other commenters in this proceeding connotes neither agreement nor disagreement by NTCA with those positions or proposals.

care universal service support mechanism" and to "improve significantly the ability of rural health care providers to respond to the medical needs of their communities."[14] As attested by the recent influx of over 57 applications totaling more than $200 million in funding requests through the two-year $60 million Rural Health Care Pilot Program, rural health care providers are interested and highly motivated to seek additional funding for their medical facilities.[15] The Commission revised the definition as part of its statutory obligation under Section 254 of the Telecommunications Act of 1996, which addresses the needs of rural areas for the provision of health care services.[16] Nowhere in the *Second Report and Order* does the Commission attempt to use this revised definition for any purpose other that the rural health care support system, and nowhere else in the USF program should this definition be used.

The Commission, indeed the general public, is well-aware of the burgeoning size of the overall universal service fund and many entities have recommended measures to control or reduce the size of the fund. For example, the Federal-State Joint Board on Universal Service recently recommended that the Commission impose an interim cap on the amount of high-cost support that competitive eligible telecommunications carriers (CETCs) can receive for each state based on an average level of CETC support distributed in 2006 in that state.[17] Restricting the list of eligible rural health care providers to those already grandfathered, plus those that qualify under the current "rural"standard, is a measure by which the Commission can control USF

[14] Second Report and Order, ¶¶ 1, 2.

[15] WC Docket No. 02-60, May 7, 2007, NTCA tally of applicants for the Rural Health Care Pilot Program.

[16] Second Report and Order, ¶ 3, *citing* 47 U.S.C. § 254(h)(1)(A), and ¶ 4.

[17] *In the Matter of High-Cost Universal Service*, Recommended Decision, WC Docket No. 05-337, CC Docket No. 96-45 (rel. May 1, 2007), ¶ 1.

growth without jeopardizing rural health care providers and their patients. Consequently, the Commission should grant the Petition but restrict the use of this "rural" definition to the rural health care support mechanism.

IV. Conclusion.

For these reasons, the Commission should grant the Petition while acknowledging that this definition of "rural" applies only to the rural health care portion of the USF and not necessarily to other funding programs within the USF.

Respectfully submitted,

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May 14, 2007

CERTIFICATE OF SERVICE

I, Adrienne Rolls, certify that a copy of the foregoing Reply Comments of the National Telecommunications Cooperative Association in WC Docket No. 02-60, DA 07-1237, was served on this 14th day of May, 2007 by first-class, United States mail, postage prepaid, or via electronic mail to the following persons:

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